function. Again this is entirely consistent with the 2:1 efficacy ratio with no penalty paid in terms of side-effects. The recently published meta-analysis is again entirely consistent with this result. The results of the Donnelly *et al.* study may also have been influenced by the use of the budesonide MDI without a spacer. There is evidence from a number of sources that the budesonide MDI produces low lung delivery which may contribute to its lesser systemic side-effects. The addition of the final paragraph about anti-leukotriene drugs is odd. Leukotriene antagonists undoubtedly shows measurable clinical improvements in asthma control; however, the evidence from reports of active comparator studies is that inhaled steroids below doses which cause any peritibation of adrenocortical function are more effective.

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Re: Asthma in the elderly: underperceived, underdiagnosed, and undertreated; a community survey

The underdiagnosis of asthma in the elderly (1), even among life-long non-smokers, may partly be a consequence of the fact that the longer the duration of asthma (or the older the patient), the more likely the resemblance to chronic obstructive pulmonary disease (COPD), perhaps because of stigmata common to both diseases, such as small airways involvement. The latter was documented in 12 out of 24 asthmatics of mean age 47 years, with symptoms of >5 years duration, in a recent pilot study (2). The undertreatment of asthmatics misclassified as having COPD can be remedied by implementing identical modules of stepped care for the two disorders (3), especially justifiable in view of the fact that the beneficial effects of inhaled corticosteroids on exercise capacity and frequency of severe relapses extend to patients with proven COPD, even when they are predominantly unresponsive to inhaled metered-dose beta-adrenergic stimulant bronchodilators (4).

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